STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004773	A. BUILDING: _____ B. WING _____	C 06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON COUNTY HOSPITAL	1141 HOSPITAL DR NW CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State hospital complaint. Complaint: IN00176477 Unsubstantiated; lack of sufficient evidence. Date of Survey: 6/30/15 Facility Number: 004773 Harrison County Hospital is in compliance with 410 IAC 15-1.6.2, Emergency Services, Indiana Hospital Licensure Rules. QA: cjl 07/06/15	S 000		